STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175506	A. BUILDING _____ B. WING _____	C 07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDBE HOME, INC	**201 W CRANE ST NORTON, KS 67654**

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F 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaint #KS00066663.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This Requirement is not met as evidenced by: The facility had a census of 73 residents with 3 sampled for review. Based on observation, interview, and record review, the facility failed to ensure 1 of 3 sampled residents remained free from physical restraints (use of a Broda chair, a reclining positioning chair), not required to treat medical symptoms. (resident #1) Findings included: - Resident #1's 12/10/12 admission MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 3 which indicated severe cognitive impairment. The resident also had delusions, continuous inattention, and disorganized thinking. He/she walked in his/her room independently, was independent in bed mobility, and required supervision of 1 person for transfer and walking in the corridor. The resident required limited assistance of 1 person for dressing and toilet use. He/she required extensive assistance of 1 person for personal hygiene. The resident had no functional	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 221	Continued From page 1	F 221		

limitations in range of motion and did not use mobility devices. The assessment indicated the resident had 1 fall in the past month prior to admission to the facility and did not use restraint devices.

Resident #1's 5/20/13 quarterly MDS (minimum data set) assessment revealed the resident had severely impaired cognition, inattention, disorganized thinking, and delusions. The resident required limited assistance of 1 person for bed mobility, dressing, toilet use, and personal hygiene. He/she required extensive assistance of 2 persons for walking in his/her room or corridor. The resident had no functional limitations in range of motion and used a wheelchair for mobility. The assessment also indicated the resident had 2 or more non-injury falls and 1 minor injury fall since the last assessment. The resident had a trunk restraint in place, used daily in the chair or when out of the bed.

Resident #1's 12/13/12 CAA (care area assessment) summary for cognitive loss revealed the resident had severe impairment and stated staff should anticipate needs and give reminders for tasks of daily living.

The 12/13/12 CAA summary related to falls stated the resident had a history of a fall on 11/30/12 (prior to admission) and stated the resident ambulated frequently without assistance with a shuffling gait and short steps. The summary indicated the facility initiated 30 minute safety checks due to decreased awareness of safety issues when ambulating.

The resident's 7/8/13 physician's order sheet included orders for personal alarms on at all times, Broda chair ordered on 4/2/13, and waist

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F 221	Continued From page 2 restraint; release every 2 hours and check resident every 15 minutes; ordered on 4/29/13. Resident #1's 5/21/13 nursing care plan included an intervention for a Broda chair to prevent falls, implemented on 4/2/13. A revision to the care plan on 4/15/13 stated, "Not to leave Broda chair in upright position...". The care plan also included interventions for the waist restraint and personal alarms. Review of the resident's nurses notes and fall/event documentation revealed the resident sustained multiple falls since admission to the facility, on 12/25/12, 1/5/13, 1/18/13, 1/28/13, 1/31/13, 2/4/13, 3/2/13, 3/31/13, 4/7/13, 4/15/13, 4/19/13, 4/27/13, 5/5/13, 6/1/13, and 6/17/13. Review of resident #1's fall event documentation revealed on 3/31/13 the resident fell from a recliner in his/her room. According to the nurses' notes on 4/2/13 staff placed the resident in a Broda chair (reclining positioning chair) "due to recent fall. Feet continue to touch floor and able to propel self around using feet and hand rails down hallway. Personal alarm still attached." The revised care plan stated, "Broda chair to prevent falls". Fall/event documentation also revealed on 4/15/13 the resident had an unwitnessed fall in his/her room. An update to the care plan on 4/15/13 stated, "not to leave Broda chair in upright position, bring out to nurses station". According to the event report, the Broda chair should be in a reclined position when not sitting at a table . Further review of fall/event documentation revealed on 4/29/13 the nursing care plan reflected implementation of a velcro waist restraint with instructions for staff to check the resident every 15 minutes and release the	F 221		

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F 221	Continued From page 3 restraint every 2 hours. The facility completed a pre-restraining assessment and physical restraint elimination assessment for the use of the waist restraint on 4/29/13. Review of the clinical record lacked a pre-restraining assessment and physical restraint elimination assessment for the use of the Broda chair for resident #1. Review of the clinical record lacked evidence at attempts to use less restrictive devices prior to the placement of the resident in a Broda chair in a reclined position. During an observation on 7/8/13 at 2:50 p.m., resident #1 sat in the hallway by his/her room in a Broda chair in a reclined position with an alarmed velcro waist restraint and also had a sensor/pad alarm on. The Broda chair did not have a foot rest or foot pedals in place. The resident's feet dangled from the knees without his/her feet touching the floor. The resident was alert and disoriented to place and time. An observation on 7/9/13 at 7:34 a.m. revealed resident #1 laying in bed, in low position as direct care staff I and J entered the resident's room. Direct care staff I assisted the resident to a sitting position on the edge of the bed and dressed the resident which included rubber soled slippers. Staff I applied a gait belt and resident #1 walked with the assistance of direct care staff I and J to the toilet. He/she had a shuffled gait with his/her body leaning backwards. After the resident used the toilet and staff provided incontinence care, staff I and J transferred him/her to the Broda chair with a pad alarm, velcro waist restraint, and reclined the chair with the resident's feet not touching the floor. During the observation the	F 221		

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F 221	Continued From page 4 resident remained confused with delusional speech, talking to persons he/she believed to be in the room. During an interview on 7/10/13 at 1:15 p.m., administrative nurse B stated the use of the Broda chair for resident #1 was for fall prevention. Nurse B revealed the intent was if the resident remained tipped back in a reclining position, it would "slow down" the resident and give staff more time to respond to the alarm and prevent the resident from falling. Administrative nurse B stated he/she did not consider the Broda chair as a restraint. The facility's 10/8/02 Physical Restraints policy defined a restraint as "a device attached or adjacent to the resident's body which restricts freedom of movement...". The policy further stated that prior to the use of restraint, the following assessments must be done: Fall assessment (if appropriate), Activity assessment (if appropriate), Restraint assessment, and Physical Therapy assessment (if appropriate). According to the policy, restraints will only be used when benefits outweigh risks and all other methods to remedy the problem have been exhausted. The facility failed to ensure resident #1 remained free from physical restraints when the facility implemented the use of a Broda chair without first thoroughly assessing the resident for the appropriate use of the chair as stated in the facility's policy.	F 221		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable	F 246		

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F 246	Continued From page 5 accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This Requirement is not met as evidenced by: The facility had a census of 73 residents with 3 selected for sample. Based on observation, interview, and record review, the facility failed to accommodate the needs of 1 of 3 sampled residents when the facility failed to provide foot pedals or support to the resident's feet when sitting in a reclined Broda chair (reclining positioning chair). (#1) Findings included: - Resident #1's 5/20/13 quarterly MDS (minimum data set) assessment revealed the resident had severely impaired cognition, inattention, and disorganized thinking. The resident required limited assistance of 2 persons for transfers, extensive assistance of 2 persons for walking, and limited assistance of 1 person for dressing, toilet use, and personal hygiene. The resident had no functional limitations in range of motion and used a wheelchair for mobility. According to the assessment the resident used a trunk restraint daily when in the chair or out of bed. Resident #1's 12/13/12 CAA (care area assessment) summary for cognitive loss stated the resident was a new admission to the facility and previously resided in an assisted living facility. The BIMS indicated severe impairment and staff should anticipate the resident's needs and give reminders for tasks of daily living.	F 246		

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The 12/13/12 CAA summary related to falls revealed the resident had a fall prior to admission and stated the resident ambulated frequently without assistance and had a shuffling gait with short steps.

Resident #1's 12/13/12 nursing care plan stated the resident transferred and ambulated independently and may need stand-by to limited assistance or wheelchair for longer distances due to shuffling gait. An update to the care plan on 2/4/13 stated the resident no longer transferred self and needed 2 person assistance. Fall prevention strategies included a personal alarm initiated on 12/25/12, a Broda chair (reclining positioning chair) initiated on 4/2/13, and a waist restraint initiated on 4/29/13.

During an observation on 7/8/13 at 2:50 p.m., resident #1 sat in the hallway by his/her room in a Broda chair in a reclined position with an alarmed velcro waist restraint and also had a sensor/pad alarm on. The Broda chair did not have a foot rest or foot pedals in place. The resident's feet dangled from the knees without his/her feet touching the floor. The resident was alert and disoriented to place and time.

During an observation on 7/9/13 at 9:52 a.m., direct care staff K and L wheeled resident #1 to his/her room in the Broda chair. After assisting the resident to the toilet, staff K and L transferred the resident back into the Broda chair, fastened the velcro waist restraint, and reclined the chair. The resident's feet dangled without touching the floor.

During an interview on 7/9/13 at 2:10 p.m., therapy staff M stated that nursing staff decided

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F 246	Continued From page 7 to use the Broda chair for resident #1 and stated that therapy staff did not evaluate the resident for the use of Broda chair. An interview on 7/9/13 at 4:35 p.m. with administrative nurse B confirmed the decision to use the Broda chair for resident #1 was a nursing decision and the resident did not have an evaluation by physical therapy for the appropriateness of the chair. Nurse B confirmed the resident's legs dangled from the chair and lacked support when staff reclined the back of the chair. The facility failed accommodate resident #1's needs when the facility failed to provide foot pedals or support to the resident's feet when sitting in a reclined Broda chair.	F 246		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This Requirement is not met as evidenced by: The facility had a census of 73 residents with 3 selected for sample.	F 274		

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F 274	Continued From page 8 Based on observation, interview, and record review, the facility failed to conduct a comprehensive assessment after 1 of 3 sampled residents experienced a significant change in their physical condition (declines in functional status, incontinence, and falls). (#1) Findings included: - Resident #1's 12/10/12 admission MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 3 which indicated severe cognitive impairment. The resident also had delusions, continuous inattention, and disorganized thinking. He/she walked in his/her room independently, was independent in bed mobility, and required supervision of 1 person for transfer and walking in the corridor. The resident required limited assistance of 1 person for dressing and toilet use. He/she required extensive assistance of 1 person for personal hygiene. He/she required supervision and set-up for eating. The assessment also described the resident's balance during transitions and walking as "not steady, but able to stabilize without staff assistance". The resident had occasional urinary incontinence and had 1 fall in the past month prior to admission to the facility. A 2/25/13 quarterly MDS assessment revealed the resident had declines in functional status, urinary incontinence, and falls when compared to the admission assessment. Previously the resident walked in his/her room independently and now required extensive assistance of 2 persons for walking in his/her room. The resident now required extensive assistance of 2 persons for bed mobility and previously had independence	F 274		

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in bed mobility. On admission the resident required supervision of 1 person for transfers and walking in the corridor and now required extensive assistance of 2 persons for transfers and walking. On the admission assessment the resident needed limited assistance of 1 person for dressing and toilet use and now required extensive assistance of 2 staff for dressing and toilet use. He/she previously required supervision and set up help for eating and now required extensive assistance of 1 person for eating. The assessment also described the resident's balance during transitions and walking as "not steady, only able to stabilize with staff assistance". On the prior assessment the resident was able to stabilize without staff assistance. The assessment also revealed the resident previously had occasional urinary incontinence and now had frequent urinary incontinence. The assessment also indicated the resident sustained 2 or more non-injury falls and 2 or more minor injury falls since the prior assessment.

Resident #1's 12/13/12 CAA (care area assessment) summary for cognitive loss stated the resident was a new admission to the facility and previously resided in an assisted living facility. The BIMS indicated severe impairment and staff should anticipate the resident's needs and give reminders for tasks of daily living.

The 12/13/12 CAA summary related to falls revealed the resident had a fall prior to admission and stated the resident ambulated frequently without assistance and had a shuffling gait with short steps.

Resident #1's 12/13/12 nursing care plan stated the resident transferred and ambulated independently and may need stand-by to limited

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assistance or wheelchair for longer distances due to shuffling gait. An update to the care plan on 2/4/13 stated the resident no longer transferred self and needed 2 person assistance. The care plan also included restorative services initiated on 2/19/13 which included range of motion, NuStep (stationary bicycle), and ambulation with 1 person assistance and gait belt 3 - 5 times per week. The care plan included an every 2 hour prompted voiding schedule and directed staff to assist the resident to the bathroom when restless or if requested. Fall prevention strategies included a personal alarm initiated on 12/25/12, a Broda chair (reclining positioning chair) initiated on 4/2/13, and a waist restraint initiated on 4/29/13.

During an observation on 7/8/13 at 2:50 p.m., resident #1 sat in the hallway by his/her room in a Broda chair in a reclined position with an alarmed velcro waist restraint and also had a sensor/pad alarm on. The Broda chair did not have a foot rest or foot pedals in place. The resident's feet dangled from the knees without his/her feet touching the floor. The resident was alert and disoriented to place and time.

An observation on 7/9/13 at 7:34 a.m. revealed resident #1 laying in bed, in low position as direct care staff I and J entered the resident's room. Direct care staff I assisted the resident to a sitting position on the edge of the bed and dressed the resident which included rubber soled slippers. Staff I applied a gait belt and resident #1 walked with the assistance of direct care staff I and J to the toilet. He/she had a shuffled gait with his/her body leaning backwards. During the observation the resident remained confused with delusional speech, talking to persons he/she believed to be in the room.

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F 274	Continued From page 11 During an interview on 7/9/13 at 3:49 p.m., administrative nurse C confirmed resident #1 experienced declines in functional status, balance, urinary incontinence, and sustained numerous falls on the 2/25/13 quarterly assessment, when compared to the admission assessment on 12/10/12. Nurse C further stated that a significant change assessment should have been completed. The facility failed to conduct a comprehensive assessment for resident #1 when he/she experienced significant declines in functional status, incontinence, and falls.	F 274		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This Requirement is not met as evidenced by: The facility had a census of 73 residents with 3 selected for sample. Based on observation, interview, and record review, the facility failed to provide necessary services to maintain personal hygiene (clean and dry clothing) for 1 of 3 sampled residents that depended on staff to carry out activities of daily living. (#3) Findings included: - Resident #3's 5/27/13 annual MDS (minimum data set) assessment revealed the resident had severe cognitive impairment, hallucinations, and	F 312		

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delusions. The resident also rejected care during 1-3 days of the assessment period. The assessment indicated the resident required extensive assistance of 1 person for transfers, toilet use, and personal hygiene. He/she had no functional limitations in range of motion, used a walker for mobility, and experienced frequent urinary incontinence.

According to the 6/4/13 CAA (care area assessment) summary for incontinence, resident #3 was unaware of his/her need to urinate, wore incontinence products, and required incontinence care.

Resident #3's 3/11/13 nursing care plan related to ADLs (activities of daily living) included an update on 7/8/13 for staff to use the sit to stand lift with assistance of 2 staff for transfers due to weakness from a recent illness [and hospitalization]. The care plan also stated the resident required assistance with toileting and hygiene needs and directed staff to take the resident to the toilet every 2 hours while awake and at night if he/she was restless.

During an observation on 7/8/13 at 3:50 p.m., direct care staff F and G assisted resident #3 to a sitting position on the edge of his/her bed. Staff F and G then transferred resident #3 from the bed to a bedside commode using a sit to stand lift. After the resident used the toilet and direct care staff G provided incontinence care, staff F placed a clean incontinence brief. Direct care staff F and G then transferred resident #3 from the commode to his/her wheelchair. The resident had a large wet area on the back of his/her jeans, soiled with urine. Staff F lowered the resident into the wheelchair while he/she wore soiled jeans. Upon request, direct care staff F and G then raised

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F 312	Continued From page 13 resident #3 in the lift and then placed clean jeans on the resident. During an interview on 7/8/13 at 4:00 p.m., direct care staff G stated he/she did not notice the wet area on resident #3's jeans. An interview on 7/9/13 at 2:15 p.m. with direct care staff H revealed resident #3 had a recent hospitalization and required more assistance because of weakness. Staff H stated resident #3 required assistance with all ADLs, including personal hygiene. An interview on 7/9/13 at 4:35 with administrative nurse B confirmed he/she expected direct care staff to check resident's clothing when they provide incontinence to ensure the resident remained clean and dry. The facility failed to provide resident #3 with clean/dry clothing after an incontinence episode.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 73 residents with 3 selected for sample. Based on observation, interview, and record review, the facility failed to ensure 1 of 3 sampled	F 323		

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residents received adequate supervision and assistive devices to prevent accidents/falls. (resident #1)

Findings included:

- Resident #1's 5/20/13 quarterly MDS (minimum data set) assessment revealed the resident had severely impaired cognition, inattention, disorganized thinking, and delusions. The resident required limited assistance of 1 person for bed mobility, dressing, toilet use, and personal hygiene. He/she required extensive assistance of 2 persons for walking in his/her room or corridor. The resident had no functional limitations in range of motion and used a wheelchair for mobility. The assessment also indicated the resident had 2 or more non-injury falls and 1 minor injury fall since the last assessment.

Resident #1's 12/13/12 CAA (care area assessment) summary for cognitive loss revealed the resident had severe impairment and stated staff should anticipate needs and give reminders for tasks of daily living.

The 12/13/12 CAA summary related to falls stated the resident had a history of a fall on 11/30/12 (prior to admission) and stated the resident ambulated frequently without assistance with a shuffling gait and short steps. The summary indicated the facility initiated 30 minute safety checks due to decreased awareness of safety issues when ambulating.

Resident #1's 12/13/12 nursing care plan for falls included the following fall prevention strategies:
* Review physical therapy screening regarding shuffling gait and adjust restorative program if indicated for strengthening /gait exercises.

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F 323	Continued From page 15 * 30 minute safety checks. Offer fluids, assistance with toileting, activity, etc during the safety checks, observe if restless or unsteady and assist as needed. * Ensure proper fitting non-skid footwear on al all times. * Provide environment free of clutter. * Assure [resident] is wearing glasses. Assure eyeglasses are clean and in good repair. A Fall Risk Assessment completed on 12/3/12 identified the resident as "high risk" for falls. Review of resident #1's nurses notes revealed the following: * On 12/25/12, the resident fell outside of bathroom door. The care plan showed a 12/25/12 update to add a personal alarm at night. * On 1/5/13, the resident fell in his/her room. The nurses note stated there was urine on the floor with a strong odor. The care plan showed a 1/5/13 update to include prompted voiding every 2 hours while awake and obtain a urinalysis. * On 1/18/13, staff observed the resident holding the alarm box and ambulating toward the bathroom, his/her feet became tangled in the cable and the resident stumbled and fell. The care plan included an update on 1/18/13 directing staff to keep the folding table put away unless it is being used. * On 1/28/13 the resident had an unwitnessed fall in his/her room. Revision of the care plan on 1/28/13 included interventions to ambulate with 1 person assist. The care plan also listed nonslip footwear, routine, checks, alarms, and to keep the folding table put away, all previously initiated in the care plan. * On 1/31/13 the resident fell in the bathroom. The updated care plan on 1/31/13 directed staff to never leave the resident unattended in the	F 323		

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bathroom.
* On 2/4/13 a facility housekeeper witnessed the resident get up and missed the chair when sitting down. Revision of the care plan directed staff to use a seat/pad alarm instead of the personal alarm.
* On 3/2/13 the resident stood from a recliner and missed the chair when sitting down. The updated care plan on 3/2/13 stated to place the resident in the hall during the busy time from 4:00 - 5:30 p.m. so he/she can watch traffic and be better monitored and to remind him/her to not get up without help.

In March of 2013, the facility converted to an electronic records system. Review of resident #1's safety events/fall documentation revealed the following:
* On 3/31/13 the resident fell from a recliner in his/her room. He/she sustained a laceration that required 2 sutures in the emergency room. According to the nurses' notes on 4/2/13 staff placed the resident in a Broda chair (reclining positioning chair) "due to recent fall. Feet continue to touch floor and able to propel self around using feet and hand rails down hallway. Personal alarm still attached." The revised care plan stated, "Broda chair to prevent falls".
* On 4/7/13 the resident was found in his/her room between the bed and recliner (foot rest raised on recliner). An update to the care plan on 4/7/13 directed staff to lay the resident down to put his/her feet up and not to put feet up in the recliner.
* On 4/15/13 resident had an unwitnessed fall in his/her room. An update to the care plan on 4/15/13 stated, "not to leave Broda chair in upright position, bring out to nurses station". According to the event report, the Broda chair should be in a reclined position when not sitting at

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F 323	Continued From page 17 a table . If he/she sets off the alarms several times, then staff should have him/her sit by the nurses' station. * On 4/19/13 the resident had an unwitnessed fall in front of his/her bed at 11:45 p.m. A revision to the care plan advised staff to schedule bathroom every 2 hours at night with assistance. * On 4/27/13 resident #1 dropped to his/her knees, attempted to crawl, then lay down on his/her side on the floor. Review of the nursing care plan lacked implementation of a new fall prevention strategy. * On 4/29/13 the nursing care plan reflected implementation of a velcro waist restraint with instructions for staff to check the resident every 15 minutes and release the restraint every 2 hours. (According to administrative nurse B on 7/10/13 at 1:15 p.m., they ordered the restraint prior to the fall on 4/27/13 and initiation of the restraint was not in response to the fall on 4/27/13). * On 5/5/13 resident #1 released the waist restraint, stood and fell. The care plan lacked implementation of any new fall prevention strategies. * On 6/1/13 the resident had an unwitnessed fall next to his/her bed. The care plan lacked revision with a new fall prevention strategy. * 6/17/13, staff found the resident on the floor in front of the Broda chair with no alarm sounding. Revision to the care plan stated, "resident is not to be left alone during the day in [his/her] room and personal alarms are to be checked every shift that they are working". The event record also revealed the resident received treatment for a urinary tract infection on 6/19/13. Review of the record lacked information related to why the alarm failed to sound. During an observation on 7/8/13 at 2:50 p.m.,	F 323		

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resident #1 sat in the hallway by his/her room in a Broda chair in a reclined position with an alarmed velcro waist restraint and also had a sensor/pad alarm on. The Broda chair did not have a foot rest or foot pedals in place. The resident's feet dangled from the knees without his/her feet touching the floor. The resident was alert and disoriented to place and time.

An observation on 7/9/13 at 7:34 a.m. revealed resident #1 lying in bed, in low position as direct care staff I and J entered the resident's room. Direct care staff I assisted the resident to a sitting position on the edge of the bed and dressed the resident which included rubber soled slippers. Staff I applied a gait belt and resident #1 walked with the assistance of direct care staff I and J to the toilet. He/she had a shuffled gait with his/her body leaning backwards. After the resident used the toilet and staff provided incontinence care, staff I and J transferred him/her to the Broda chair with a pad alarm, velcro waist restraint, and reclined the chair with the resident's feet not touching the floor. During the observation the resident remained confused with delusional speech, talking to persons he/she believed to be in the room.

During an interview on 7/9/13 at 2:29 p.m., direct care staff J stated resident #1 required 2 staff for transfers and walking. Staff J further stated the resident had a "seat belt alarm" and a pad alarm that he/she sat on. He/she also stated if the resident was awake, they keep the resident where staff can see him/her and they also keep the Broda chair reclined.

An interview on 7/9/13 at 3:30 p.m. with licensed nurse D revealed it is the responsibility of the charge nurse to look at what causes a resident to

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F 323	Continued From page 19 fall and then initiate an appropriate intervention to prevent it from happening again. During an interview on 7/10/13 at 1:15 p.m., administrative nurse B confirmed new fall prevention strategies should be implemented after an evaluation of each fall. He/she stated they "ran out of interventions" for resident #1 and the care plan lacked new interventions for the falls on 4/27/13, 5/5/13, and 6/1/13. The facility's undated Falls policy/procedure stated, "The care plan will be updated, the fall list intervention list will be reviewed by the licensed nurse and updated." The facility failed to ensure this cognitively impaired resident had effective interventions in place for fall prevention after resident #1 sustained multiple falls.	F 323		